

Student Name:

MS-1 MS-2

Clinician Name:

Date:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date** | **Hours** | **Date** | **Hours** | **Date** | **Hours** | **Date** | **Hours** |
| **Clinical Experience** |  |  |  |  |  |  |  |  |
| **Faculty**  **Signature** |  | |  | |  | |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date** | **Hours** | **Date** | **Hours** | **Date** | **Hours** | **Date** | **Hours** |
| **Clinical**  **Experience** |  |  |  |  |  |  |  |  |
| **Faculty**  **Signature** |  | |  | |  | |  | |

# Program Evaluation:

My favorite aspect of my early clinical experience was:

My least favorite aspect of my early clinical experience was:

My overall satisfaction rating for my early clinical experience is:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Very  Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied |
|  |  |  |  |  |

**Completion Deadline for Fall Semester**: December 31

# Completion Deadline for Spring Semester: May 31

Return this form to Laura Christopher, Asst. Director of Academic and Career Services

[christopherl@marshall.edu](mailto:christopherl@marshall.edu) or fax 304-691-1727.

CMEs will be awarded upon receipt of documentation.

Thank you for your time!